MDR: M4-02-1874-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,811.20 for date of service 02/01/01.

   b. The request was received on 03/12/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/08/02
   b. HCFA 1450
   c. Example EOB(s) from other carriers
   d. EOB
   e. Medical Records
   f. Povider's Initial Request for Medical Dispute dated 01/30/02
   Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 03/19/02
   b. Carrier's additional response dated 03/05/02 per fax date, not date stamp
   c. HCFA 1450
   d. EOB
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 03/13/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 03/14/02. The response from the insurance carrier was received in the Division on 03/19/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 03/08/02 that, "We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that … should reimburse us more appropriately as $2236.00 does not cover our costs to perform this surgery…has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges. Also group insurance companies are allowing 100% of our billed charges. Enclosed are examples of bills for the same type of treatment of other patients and their insurance companies interpretation of fair and reasonable…"

2. Respondent: The Respondent's representative states in the correspondence dated 03/19/02 that, "THE CARRIER, IN DETERMINING WHAT CONSTITUTES A 'FAIR AND REASONABLE RATE' DID CONSIDER THE MEDICARE, PPO, AND HMO PAYMENTS, AND REVIEWED THE COMMISSION'S OWN GUIDELINES FOR ACUTE CARE. ACUTE CARE GUIDELINES STATE THAT $1118.00 IS A VALID REIMBURSEMENT FOR A FULL DAY OF INPATIENT CARE, OR APPROXIMATELY 24 HOURS. BY DEFINITION, OUTPATIENT OR AMBULATORY SURGICAL SERVICES ARE THOSE THAT REQUIRE LESS THAN 90 MINUTES ANESTHESIA TIME AND LESS THAT FOUR HOURS OF RECOVERY. THIS MEANS THE PATIENT RECEIVES CARE FROM THE FACILITY FOR ¼TH OF THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID AT THE **EQUIVALENT OF** A ONE DAY INPATIENT STAY IN THIS CASE, THE PATIENT HAD A MORE EXTENSIVE PROCEDURE AND THE FACILITY WAS PAID AT TWICE THE CARRIER'S 'FAIR AND REASONABLE', OR $2236.00. THE SAME AS IF THE PATIENT HAD BEEN INPATIENT FOR TWO FULL DAYS. **THE ACUTE CARE FEE GUIDELINES WERE USED AS A CONSIDERATION IN DETERMINING REIMBURSEMENT-HOWEVER, THIS DOES NOT MEAN THAT INPATIENT GUIDELINES WERE APPLIED TO THIS SERVICE.** THE CARRIER HAS CONSISTENTLY APPLIED THIS REIMBURSEMENT RATIONALE FOR ALL A.S.C. SERVICES PROVIDED IN 2001. PAYING $1118.00- THIS PARTICULAR CASE WAS ALLOWED ADDITIONAL."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 02/01/01.

2. The provider billed $7,047.20 for disputed date of service, 02/01/01.

3. The carrier paid the provider $2,236.00 for date of service, 02/01/01.

4. The amount in dispute for the date of service is $4,811.20.

5. The carrier denied additional payment for date of service 02/01/01 by denial code, "F – REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES., F - REIMBURSEMENT FOR YOUR RESUBMISSION INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCODRING [sic] TO STATE FEE GUIDELINES AND/OR STATE RULES AND REGULATIONS." and "M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE." In both party responses, the provider and the carrier accept fair and reasonable as the denial of the billed services. This dispute will be considered a fair and reasonable dispute.

6. The services provided by the provider include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

7. The provider unbundled the treatment services for an ASC on the HCFA 1450. According to Rule 133.1 (a) (E) (16), unbundling is "Submitting bills in a fragmented way, using separate billing codes for multiple treatments or services when there is a single billing code that includes all the treatments or services that were billed separately, or fragmenting one treatment or service into its component parts and coding each component part as if it were a separate treatment or service."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011 (d) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

Commission Rule 133.304 (i) (1-4) requires the carrier to explain how they arrived at what they consider a fair and reasonable reimbursement. The carrier submitted their methodology and though, the entire methodology may not necessarily be concurred with by the Medical Review Division, the requirements of the Rule has been met.

The provider submitted additional reimbursement data (EOBs from various carriers) in an attempt to demonstrate payments of fair and reasonable documentation for treatment of an injured individual of an equivalent standard of living in their geographical area. The provider's documentation failed to meet the criteria of 133.307 (g) (3) (D) of demonstrating, discussing, and justifying fair and reasonable reimbursement from other carriers for similar treatment.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine based on the parties submission of information, who has provided the more persuasive evidence. In this particular case, the carrier submitted a methodology, as required by 133.303 (i), which is sufficient to establish that the amount requested by the provider is not fair and reasonable. The health care provider has the burden to prove that the fees paid by the carrier were not fair and reasonable. The provider submitted EOB(s) from other carriers, but the documentation is insufficient to determine if the charge of the provider is fair and reasonable. The carrier failed to meet the criteria of 413.011 (d), therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 17th day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division